

# Welcome!

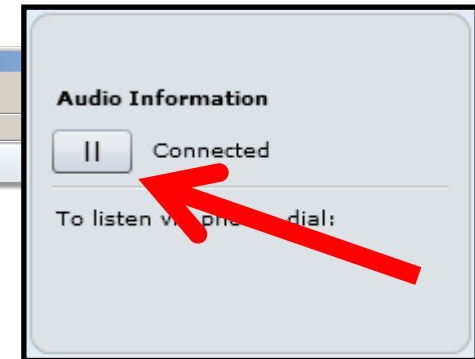
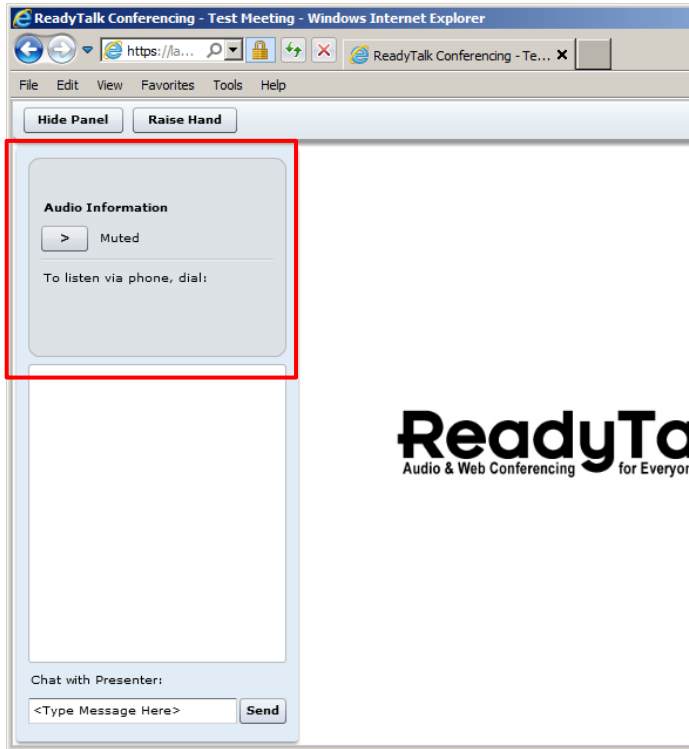
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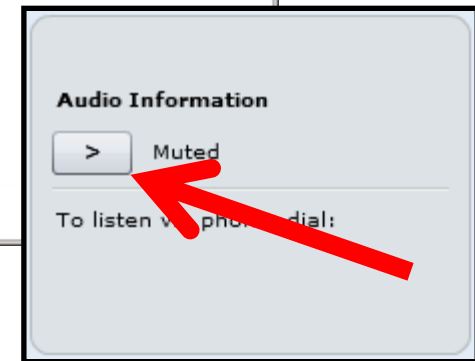
# Troubleshooting Audio

Audio from computer speakers breaking up?  
Audio suddenly stop?

- Click Pause button
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Step 1



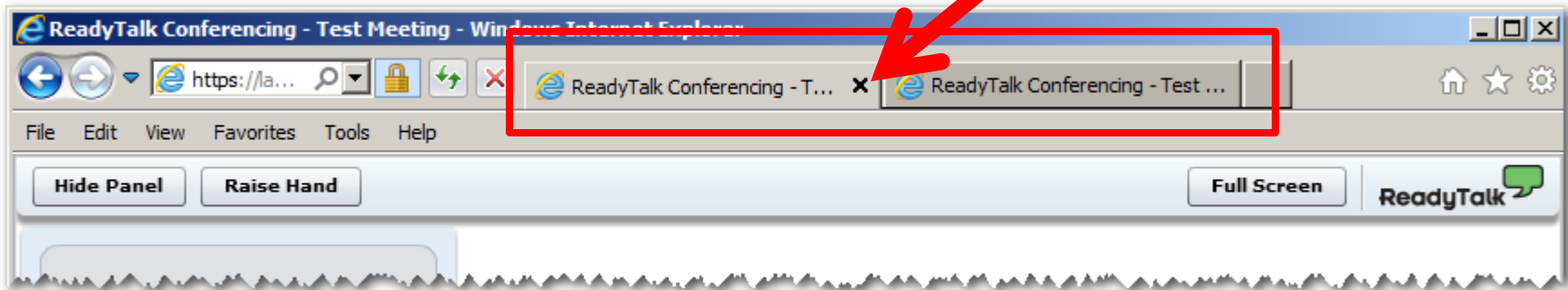
Step 2



Location of Audio Controls

# Troubleshooting Echo

- Hear a bad echo on the call?
- Echo is usually caused by multiple connections to a single event.
- Close all but one browser/tab and the echo will clear up.



**Example of Two Connections to Same Event**

# Submitting Questions

Type questions in the “Chat with Presenter” section, located in the bottom-left corner of your screen.



The screenshot shows a web browser window with a CMS interface. On the left is a chat window titled "Chat with Presenter" with a text input field and a "Send" button. On the right is a presentation slide with the CMS logo and the following text:

**Specifications Manual, Version 4.4a,  
Changes & Hospital VBP Program  
Improvement Series: MSPB**

November 18, 2014, 10 a.m. & 2 p.m. ET

<i>Candace Jackson, RN, Hospital IQR Support Contract Lead</i>	<i>Donna Isgett, Sr. Vice President Corporate Quality and Safety McLeod Medical Center</i>
<i>Cindy Cullen, Mathematica Policy Research</i>	<i>Amanda Molski, Quality Coordinator Memorial Hospital Sweetwater County</i>
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# **FY 2016 IPPS/LTCH PPS Final Rule**

## **PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program**

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**August 27, 2015**

# Acronyms

- **ACIP** Advisory Committee on Immunization Practices
- **AMA** American Medical Association
- **APU** Annual Payment Update
- **CAUTI** Catheter-Associated Urinary Tract Infections
- **CDC** Centers for Disease Control and Prevention
- **CDI** *Clostridium difficile* Infection
- **CLABSI** Central Line-Associated Bloodstream Infection
- **CMS** Centers for Medicare & Medicaid Services
- **CY** Calendar Year
- **FacWideIN** Facility-wide Inpatient
- **FR** Federal Register
- **FY** Fiscal Year
- **HAI** Healthcare-Associated Infection
- **HCAHPS** Hospital Consumer Assessment of Healthcare Providers and Systems Survey
- **HCP** Healthcare Personnel
- **HRRP** Hospital Readmissions Reduction Program
- **IPPS** Prospective Payment System
- **IPPS** Inpatient Prospective Payment System
- **IQR** Inpatient Quality Reporting
- **LabID** Laboratory Identification
- **LTCH** Long Term Care Hospital
- **MRSA** Methicillin-Resistant *Staphylococcus aureus*
- **MUC** Measure Under Consideration
- **NHSN** National Healthcare Safety Network
- **NQF** National Quality Forum
- **NQS** National Quality Strategy
- **PCHQR** PPS-Exempt Cancer Hospitals Quality Reporting
- **Q** Quarter
- **SCIP** Surgical Care Improvement Project
- **SSI** Surgical Site Infection

# Save the Date

- **September 24, 2015 Webinar:**  
*Pain Assessment - NQF #0384 and #0383*
- **October 22, 2015 Webinar:**  
*Tentative - New NHSN Measures for the PCHQR*

# Purpose

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- Summarize the FY 2016 IPPS Final Rule updates to the PCHQR Program
- Review Comments Submitted and Responses



# Objectives

At the conclusion of this presentation, attendees will understand the final changes to the PCHQR Program found in the Final Rule issued in August 2015, which will apply to reporting beginning in January 2016.

They will be able to:

- Find the FY 2016 Final Rule text
- Identify PCHQR changes within the FY 2016 Final Rule
- Discuss Final Rule measures as part of process improvement strategies

# PCHQR Program

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## **FY 2016 FINAL RULE OVERVIEW**

# Summary of Final Changes

- Removal of six Surgical Care Improvement Project (SCIP) Measures
- Addition of new Quality Measures
- Possible future Quality Measure topics
- Administrative changes, including but not limited to:
  - Technical Specifications for Quality Measures
  - Public Display Requirements
  - Form, Manner, and Timing of Data Submission

# Summary of Finalized PCHQR Program Measures Beginning FY 2018

NQF #	Safety and Healthcare-Associated Infection (HAI)
0139	CDC NHSN CLABSI Outcome Measure*
0138	CDC NHSN CAUTI Outcome Measure*
0753	Harmonized Procedure-Specific SSI Outcome Measure (currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery)*
1717	CDC NHSN Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure**
1716	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure**
0431	CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel [HCP]**
NQF #	Clinical Process/Cancer Specific Treatments
0233	Adjuvant Chemotherapy is considered or administered within four months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) Colon Cancer*
0559	Combination Chemotherapy is considered or administered within four months (120 days) of diagnosis for women under 70 with AJCC T1c or Stage II or III Hormone Receptor Negative Breast Cancer*
0220	Adjuvant Hormonal Therapy*

\* Previously finalized measures

\*\*Finalized for the FY 2018 program and subsequent years

 Yellow Highlight indicates a new measure

# Summary of Finalized PCHQR Program Measures Beginning FY 2018 (cont.)

NQF #	Clinical Process/Oncology Care Measures
0382	Oncology: Radiation Dose Limits to Normal Tissues*
0383	Oncology: Plan of Care for Pain *
0384	Oncology: Pain Intensity Quantified*
0390	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients*
0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients*
NQF #	Patient Engagement/Experience of Care
0166	HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems Survey]*
NQF #	Clinical Effectiveness Measure
1822	External Beam Radiotherapy for Bone Metastases*

\*Previously finalized measures

# PCHQR Program

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## **FY 2016 FINAL RULE: IPPS PROGRAM CHANGES AFFECTING THE PCHQR PROGRAM**

# IPPS Statutory Authority Regulations

The FY 2013 Final Rule dated August 31, 2012, included the following Statutory Authority clauses:

- Section 3005 of the Affordable Care Act added new sections 1866(a)(1)(W) and (k) to the Act.
- Section 1866(k)(1) required that starting in FY 14 PCHs had to submit data to the Secretary in accordance with section 1866(k)(2) of the Act with respect to such a fiscal year.

# PCHQR-Related Statutory Authority

The PCHQR Program's statutory bases have included:

- FY 2016 IPPS/LTCH PPS final rule (80 FR 49713 through 49723)
- FY 2015 IPPS/LTCH PPS final rule (79 FR 50277 through 50286)
- FY 2014 IPPS/LTCH PPS final rule (78 FR 50837 through 50853)
- FY 2013 IPPS/LTCH PPS final rule (77 FR 53555 through 53567)

The FY 2016 Final Rule, as published in the Federal Register is located at:

<http://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf>



# PCHQR Program

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## **FINALIZED MEASURE REMOVAL**

# SCIP Measure Removal Beginning with Q4 2015 Discharges

- Q1 2015 Discharges:
  - Data submission required with submission period of July 1–August 15, 2015
- Q2 and Q3 2015 Discharges:
  - Data submission required with submission period of July 1–August 15, 2016
- **Starting with Q4 2015 Discharges:**
  - **No data submission**

# SCIP Measures for Removal

NQF #	Measure Title
0218	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours Prior to Surgery to 24 Hours After Surgery
0453	Urinary Catheter Removed on Post-Operative Day One (POD1) or POD2 with Day of Surgery Being Day 0
0527	Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
0528	Prophylactic Antibiotic Selection for Surgical Patients
0529	Prophylactic Antibiotic Discontinued within 24 Hours After Surgery End Time
0284	Surgery Patients in Beta-Blocker therapy Prior to Admission who Receive a Beta-Blocker During the Perioperative Period

# Logic for Finalized Removal of SCIP Measures

Rationale	Rule/ Authority
<p>SCIP measures “topped-out” in Hospital IQR Program and have been removed from that program.</p>	<p><b>FY 2015 IPPS/LTCH PPS Final Rule (79 FR 50205)</b></p> <p><b>and</b></p> <p><b>FY 2016 IPPS/LTCH PPS Final Rule</b></p>
<p>Removal to align with the Hospital IQR Program.</p>	
<p>Without inclusion in the IQR Program, it is no longer operationally feasible to collect these measures under the PCHQR Program.</p>	
<p>Removing SCIP measures reduces PCHs’ administrative burden and maintenance costs.</p>	
<p>Allow focus of CMS IT systems on PCHQR Program measures more closely linked with clinical outcomes.</p>	

# SCIP and Public Reporting Comments and Responses

There were a total of five comments about SCIP measure removal published in the Final Rule.

- Overall the comments were supportive of the removal of the SCIP measures from the PCHQR program.
- There were specific comments about the:
  - Reduction in data collection burden
  - Timing of removal and reporting
  - Relationship between removing these metrics from the PCHQR and the previous removal from the IQR program
- For the detailed responses to these comments, please refer to the Federal Register.

# SCIP Status

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After consideration of the public comments we received, **we are finalizing our proposal to remove these six SCIP measures from the PCHQR Program beginning with fourth quarter (Q4) 2015 discharges** and for subsequent years.

# PCHQR Program

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## **FINALIZED NEW MEASURES**

# Overview of Finalized New Measures

For the FY 2018 payment determination and subsequent years, CMS finalizes the addition of three new NHSN HAI quality measures:

1. **NQF #1717** Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure
2. **NQF #1716** Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure
3. **NQF #0431** Influenza Vaccination Coverage Among Healthcare Personnel Measure (HCP)



# History of the New NHSN Measures

- The **finalized measures** are currently reported under the Hospital IQR Program
- They were:
  - Publicly posted and available in a document entitled “List of Measures Under Consideration (MUC) for December 1, 2014”
  - Submitted to the Measure Applications Partnership (MAP) which:
    - Is a public-private partnership
    - Was convened by the NQF for providing input to the Secretary on the selection of certain quality and efficiency measures
    - Supported all three measures for the PCHQR Program

# Why are the New HAI Measures Important?

HAIs can have devastating emotional, financial, and medical consequences:

- CDI and MRSA are significant causes of morbidity and mortality
  - Tens of thousands of lives lost annually
- Approximately one in every 25 inpatients develops an infection related to hospital care
- HAIs cost the U.S. healthcare system billions of dollars annually

*Statistics taken from the FY 2016 Final Rule*

# Why Report HAIs in the PCHQR Program?

- Adoption of the new HAI measures reinforces CMS' commitment to increasing patient safety
  - By partnering with hospitals (e.g., CMS' Partnership for Patients), hospital care becomes:
    - Safer
    - More reliable
    - Less costly
- These prevention measures will:
  - Decrease injury and morbidity
  - Allow patients to heal without complications
- Cancer patients face increased exposure to risk
  - Existence of a serious underlying illness or immunocompromised condition increases the risk of CDIs
  - Prolonged antibiotic exposure increases risk
  - Long length of stay in a healthcare setting increases risk

# Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection Outcome Measure CDI (NQF #1717)

- CDI data report the SIR of hospital-onset CDI LabID events among all patients in a facility
- The Numerator is the total number of observed hospital-onset CDI LabID events among all inpatients in a facility
  - Excluding well-baby nurseries and Neonatal Intensive Care Units
- The Denominator is the total number of predicted hospital-onset CDI LabID events
  - Calculated by multiplying the number of inpatient days for the facility by the hospital-onset CDI LabID event rate for similar types of facilities (obtained from a standard population)

# CDI Measure Goals: Then and Now

## Then

- **Baseline:** 2010–2011 baseline SIR of 1.0
- **National Goal:** Reduce the incidence of facility-onset CDI overall by 30%
  - Resulting in a SIR of 0.70 by no later than 2013
- **Achieved – Yes/No:** Not yet attained, progress minimal. Facility-onset CDI decreased by only 2% as of the end of CY 2012
  - Resulting in a SIR of 0.98

## Now

- **Baseline:** 2015 baseline SIR of 1.0
- **Revised National Goal:** Reduce facility-onset of CDI by 30%
  - Resulting in a SIR of 0.70 by no later than 2020
- **Achieved – Yes/No :** To be determined

# Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure (NQF #1716)

- MRSA data reports the **SIR** of hospital-onset unique blood source MRSA LabID events among all inpatients in a facility
- The **Numerator** is the total number of observed hospital-onset unique blood source MRSA LabID events among all inpatients in the facility
- The **Denominator** is the total number of predicted hospital-onset unique blood source MRSA LabID events
  - Calculated by multiplying the number of inpatient days for the facility by the hospital-onset MRSA bacteremia LabID event rate for similar types of facilities (obtained from a standard population)

# MRSA Measure Goals: Then and Now

## Then

- **Baseline:** 2009 baseline SIR of 1.0
- **National Goal:** Reduce the incidence of facility-onset MRSA infections by 50 percent
  - No later than 2020
- **Achieved – Yes/No:** Unable to assess but progress slow. So far, facility-onset MRSA infections decreased by only 3% as of the end of CY 2012
  - Resulting in a SIR of 0.97

## Now

- **Baseline:** 2015 baseline SIR of 1.0
- **Revised National Goal:** Reduce facility-onset of MRSA infections by 50%
  - Resulting in a SIR of 0.0 by no later than 2020
- **Achieved – Yes/No :** To be determined

# Why Implement the HAI Measures for PCH?

- **Collection** of data on CDI and MRSA in the hospital setting and **adoption** of these measures for the PCH setting will:
  - Ensure the highest quality of care for cancer patients
  - Support Health and Human Services' (HHS') "National Action Plan to Prevent Healthcare Associated Infections (HAIs)"
- **Collection** and **evaluation** of HAI data will:
  - Allow PCH staff to assess their facility's infection control efforts and identify areas for improvement
  - Increase patient protection and safety thereby reducing/preventing adverse infections in the PCH setting



# Why Implement the HAI Measures for PCH? (cont.)

- The addition of the MRSA Measure to PCHQR is especially important because:
  - Invasive MRSA infections during a hospital stay cause approximately 18,000 deaths per year
  - Cancer patients have an increased risk for MRSA infections
  - Older adults with weakened immune systems who are receiving hospital inpatient care are most susceptible.

# HAI Data Collection and Reporting

The Final Rule allows for a common mechanism of data collection and reporting to CDC's NHSN that all hospitals, including PCHs, would use to:

- Uniformly submit and report measure data
- Inform their clinicians of the impact of targeted prevention efforts
- Provide PCH staff with a means to evaluate their infection control efforts and improvement needs
- Continue efforts to increase patient protection and safety and prevent adverse infections in the PCH setting

# CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431)

The Influenza Vaccination Coverage Among HCP measure is important in the PCH environment because:

- Influenza has widespread and serious consequences
- Persons infected with the influenza virus, including subclinical infection, facilitate influenza virus transmission to persons at higher risk for complications, e.g., immunocompromised cancer patients
- The Advisory Committee on Immunization Practices (ACIP) recommends that all healthcare personnel (HCP) and persons in training for health care professions receive an annual vaccination against influenza

# CDC NHSN HCP Measure Numerator

The **Numerator** is HCP in the denominator population who, from October 1 (or when the vaccine became available) through March 31 of the following year, either:

- **Received an influenza vaccination** administered at the facility, or reported in writing (paper or electronic) or provided documentation that the influenza vaccination was received elsewhere
- Were determined to have a **medical contraindication or history of Guillain-Barré Syndrome** within six weeks after a previous influenza vaccination
- **Declined** the influenza vaccination
- Had an **unknown vaccination status**

# CDC NHSN HCP Measure

## Denominator

- The **Denominator** includes the number of HCP who are working in the healthcare facility for **at least one working day beginning October 1 (or when the vaccine becomes available) and ending March 31 of the following year**, regardless of clinical responsibility or patient contact, and includes:
  - Employees
  - Licensed independent practitioners
  - Adult students/trainees and volunteers

# Measure Goals: Then and Now

## Then

- In the 2012–2013 flu season, the vaccination rate for healthcare personnel was 72.0 percent
- The 2013–2014 flu season vaccination rate was 75.2 percent

## Now

- One of the Healthy People 2020 goals is to achieve a vaccination rate among healthcare personnel of 90 percent nationally by the year 2020

*Statistics taken from the FY 2016 Final Rule*

# Why Implement the CDC NHSN HCP Measure for PCH?

Implementing the HCP Measure would:

- Reduce work absenteeism and losses in productivity
- Supports CMS efforts to prevent unnecessary additional or prolonged hospitalizations (and associated costs)
- Reduce premature deaths among patients
- Reduce incidence of nosocomial influenza and prevent adverse outcomes in the PCH setting, especially for high risk cancer patients\*
- Address the NQS Patient Safety domain
  - Ensuring the highest quality of care for cancer patients
- Provide a mechanism for tracking the percent of healthcare personnel who receive the influenza vaccination

\*According to CDC guidelines, patients who currently have cancer or who have had certain types of cancer in the past (such as lymphoma or leukemia), are at high risk for complications from influenza, including hospitalization and death

# HCP Data Collection and Reporting

The Final Rule allows for a common mechanism of data collection and reporting to CDC's NHSN that all hospitals, including PCHs, would use to:

- Uniformly submit and report measure data
- Inform their clinicians of the impact of targeted prevention efforts
- Provide PCH staff with a means to evaluate their infection control efforts and improvement needs
- Continue efforts to increase patient protection and safety and prevent adverse infections in the PCH setting
  - Prevent unnecessary additional or prolonged hospitalizations (and associated costs)
  - Decrease premature deaths among cancer patients



# HAI Comments and Responses

The Final Rule contains nine comments and responses related to the healthcare-associated measures.

- These measures will be addressed in more detail in a Webinar scheduled for October 22, 2015 entitled, *New NHSN Measures for the PCHQR*.
- Overall, comments were supportive of the inclusion of these measures.
- Specific comments addressed differences:
  - Of Cancer patients from other patients
  - In diagnostics
  - Within various types of cancer patients

Attendees are directed to the Final Rule published in the Federal Register for specific comments and responses.

# Topic Summary of Adopted and Newly Finalized PCHQR Program Measures Beginning with the FY 2018 Program

Safety and Healthcare-Associated Infection – HAI	
Measure Name	NQF #
CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure*	0139
CDC NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure*	0138
Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure* [currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery]	0753
CDC NHSN Facility-wide Inpatient Hospital-onset <i>Clostridium difficile</i> Infection (CDI) Outcome Measure**	1717
CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) Bacteremia Outcome Measure**	1716
CDC NHSN Influenza Vaccination Coverage Among Healthcare Personnel (HCP)**	0431

# Finalized PCHQR Measures Beginning with FY 2018 Program

## Clinical Process/Cancer-Specific Treatments

Measure Name	NQF #
Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer*	0223
Combination Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer*	0559
Adjuvant Hormonal Therapy*	0220

## Clinical Process/Oncology Care Measures

Measure Name	NQF #
Oncology: Radiation Dose Limits to Normal Tissues*	0382
Oncology: Plan of Care for Pain*	0383
Oncology: Pain Intensity Quantified*	0384
Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients*	0390
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients*	0389

\*Previously finalized measures.

\*\* Adopted beginning with the FY 2018 program in this Final Rule.

# Finalized PCHQR Measures

## Beginning with FY 2018 Program (cont.)

### Patient Engagement/Experience of Care

Measure Name	NQF #
HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems Survey)*	0166

### Clinical Effectiveness Measure

Measure Name	NQF #
External Beam Radiotherapy for Bone Metastases*	1822

# Potential Quality Measures Topics and Domain Areas for Future Rules

- Discussed in FY 2015 IPPS/LTCH PPS final rule (79 FR 50280)
- Public comment and specific suggestions for measure topics addressing the following CMS Quality Strategy domains are welcomed:
  - Making care affordable
  - Communicating and coordinating
  - Working with communities to promote best practices

# Comments on Potential Quality Measure Topics for Future Years

A total of nine comments were received regarding potential quality-related measure topics for future years.

- The major themes included:
  - Request of a focus on outcome and quality of life metrics, particularly patient reported outcomes
  - Consideration of data collection burden
  - Alignment with national priorities
  - Consideration of risk adjustment
  - Further specificity as to measures “topping out”

We are appreciative of these comments and suggestions. As with all of our programs, we are fully committed to engaging and partnering with all stakeholders to ensure success, and most importantly, improve quality of care.

# Maintenance of Technical Specifications

- Technical specifications for the PCHQR Program measures are periodically updated
  - Specifications may be found on the *QualityNet* website at:  
<https://qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774479863>
- The Final Rule does not include any changes to the policy found in the FY 2015 IPPS/LTCH PPS final rule (79 FR 50281) which describes a sub-regulatory process for making non-substantive updates to measures used for the PCHQR Program

PCHQR Program

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# **PUBLIC DISPLAY REQUIREMENTS**



# *Hospital Compare: Public Display Requirements for Five PCHQR Measures*

## Summary of Finalized Public Display Requirements

Measures	NQF #	Public Reporting
Adjuvant Chemotherapy is Considered or Administered Within Four Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer	0233	2014 and subsequent years
Combination Chemotherapy is Considered or Administered Within Four Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer	0559	
Adjuvant Hormonal Therapy	0220	2015 and subsequent years
CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	2017 and subsequent years
CDC NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure	0138	

# Public Display Requirements

Six additional PCHQR measures are proposed for public display on *Hospital Compare* beginning in 2016 and for subsequent years:

- Oncology: Radiation Dose Limits to Normal Tissues (NQF #0382)
- Oncology: Plan of Care for Pain (NQF #0383)
- Oncology: Pain Intensity Quantified (NQF #0384)
- Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients (NQF #0390)
- Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Patients (NQF #0389)
- HCAHPS (NQF #0166)

# Public Display: Comments and Responses

There were a total of eight comments and responses regarding Public Display.

- Several commenters were supportive and also noted the benefit of alignment across programs.
- Specific comments were directed towards:
  - CAUTI reporting
  - CLABSI reporting
  - Clarity on Radiation Dose Limits to Normal Tissues
  - Clarity on sampling for Paired Metrics of Pain Intensity Quantified and Plan of Care for Pain

Please refer to the Final Rule for details of these comments and responses

# Public Display Requirements

Summary of Previously Adopted and Newly Finalized Public Display Requirements		
Measures	NQF #	Public Reporting
• Adjuvant Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis to Patients Under the Age of 80 with AJCC III (lymph node positive) Colon Cancer	0233	2014 and subsequent years
• Combination Chemotherapy is Considered or Administered Within 4 Months (120 days) of Diagnosis for Women Under 70 with AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer	0559	
• Adjuvant Hormonal Therapy	0220	2015 and subsequent years
• Oncology: Radiation Dose Limits to Normal Tissues●	0382	2016 and subsequent years
• Oncology: Plan of Care for Pain	0383	
• Oncology: Pain Intensity Quantified	0384	
• Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Patients	0390	
• Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Patients	0389	
• HCAHPS	0166	2017 and subsequent years
• CDC NHSN Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure	0139	
• CDC NHSN Catheter-Associated Urinary Tract Infections (CAUTI) Outcome Measure	0138	

# Form, Manner, and Timing of Data Submission

## Proposed CDC NHSN CDI (NQF #1717) and CDC NHSN MRSA (NQF #1716) Measures Reporting Periods and Submission Timeframes Beginning with the FY 2018 Program

Program Year (FY)	Reporting Periods (CY)	Data Submission Deadlines (CY)
2018	<b>Q1 2016 events</b> (January 1–March 31, 2016)	<b>August 15, 2016</b>
	<b>Q2 2016 events</b> (April 1–June 30, 2016)	<b>November 15, 2016</b>
	<b>Q3 2016 events</b> (July 1–September 30, 2016)	<b>February 15, 2017</b>
	<b>Q4 2016 events</b> (October 1–December 31, 2016)	<b>May 15, 2017</b>
Subsequent Years	<b>Q1 events</b> (January 1–March 31 of year two years before the program year)	<b>August 15</b> of year two years before the program year
	<b>Q2 events</b> (April 1–June 30 of year two years before the program year)	<b>November 15</b> of year two years before the program year
	<b>Q3 events</b> (July 1–September 30 of year two years before the program year)	<b>February 15</b> of year one year before the program year
	<b>Q4 events</b> (October 1–December 31 of year two years before the program year)	<b>May 15</b> of year one year before the program year

# Form, Manner, and Timing of Data Submission

## Proposed CDC NHSN HCP (NQF #0431) Measure Reporting Periods and Submission Timeframes Beginning with the FY 2018 Program

Program Year (FY)	Reporting Periods (CY)	Data Submission Deadlines (CY)
2018	Q4 2016 counts (October 1–December 31, 2016)	May 15, 2017
	Q1 2017 counts (January 1–March 31, 2017)	
Subsequent Years	Q4 counts (October 1–December 31 of year two years before the program year)	May 15 of year One year before the program year
	Q1 counts (January 1–March 31 of year one year before the program year)	

# PCHQR Program

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## **CONTINUING EDUCATION CREDIT PROCESS**

# Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
  - Board of Registered Nursing (Provider #16578)
    - It is your responsibility to submit this form to your accrediting body for credit.



# CE Credit Process

- Complete the ReadyTalk<sup>®</sup> survey that will pop up after the webinar, or wait for the survey that will be sent to all registrants within the next 48 hours.
- After completion of the survey, click “done” at the bottom of the screen.
- Another page will open that asks you to register in HSAG’s Learning Management Center.
  - This is a separate registration from ReadyTalk
  - Please use your PERSONAL email so you can receive your certificate
  - Healthcare facilities have firewalls up that block our certificates

# CE Credit Process: Survey

No

Please provide any additional comments

**10. What is your overall level of satisfaction with this presentation?**

Very satisfied

Somewhat satisfied

Neutral

Somewhat dissatisfied

Very dissatisfied

If you answered "very dissatisfied", please explain

**11. What topics would be of interest to you for future presentations?**

**12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.**

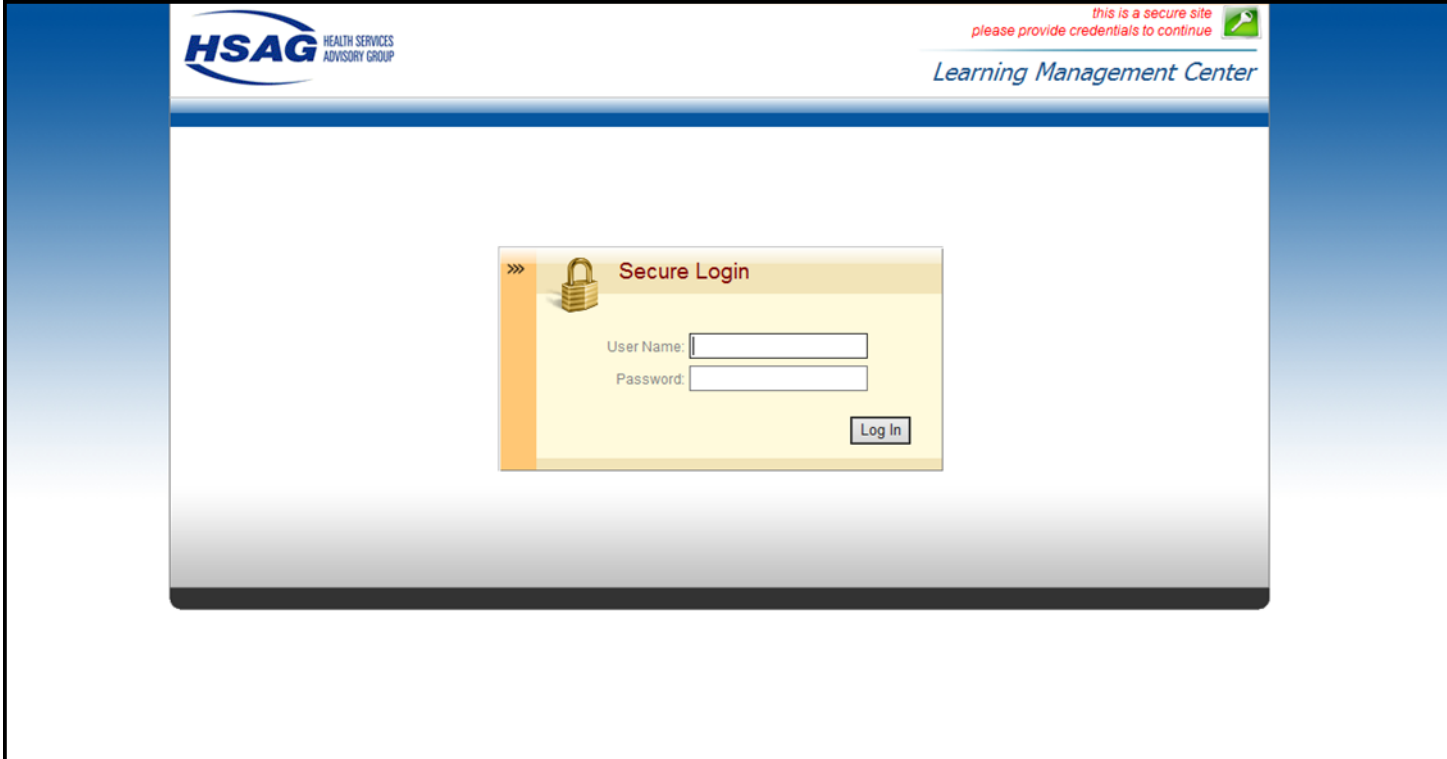
Done

Powered by [SurveyMonkey](#)  
Check out our [sample surveys](#) and create your own now!

# CE Credit Process: New User

The screenshot shows a web page for the HSAG Learning Management Center. At the top left is the HSAG logo with the text "HEALTH SERVICES ADVISORY GROUP". At the top right, there is a security notice: "this is a secure site please provide credentials to continue" next to a small green icon. Below this is the text "Learning Management Center". The main heading of the page is "Learning Center Registration: OQR: 2015 Specifications Manual Update - 1-21-2015". Below the heading are four input fields: "First Name:" and "Last Name:" on the top row, and "Email:" and "Phone:" on the bottom row. The "Phone:" field has a small icon of a telephone handset. Below the input fields is a "Register" button. The entire form is enclosed in a white box with a blue border.

# CE Credit Process: Existing User



The screenshot displays the login interface for the HSAG Learning Management Center. At the top left is the HSAG logo with the text "HEALTH SERVICES ADVISORY GROUP". At the top right, a red security notice reads "this is a secure site please provide credentials to continue" next to a small green icon. Below this is the text "Learning Management Center". The central focus is a "Secure Login" box with a yellow background and a lock icon. It contains two input fields: "User Name:" and "Password:". A "Log In" button is positioned at the bottom right of the login box.

# QUESTIONS?

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